

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1940
73

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10150

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone Co Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 minutes
(Specify whether years, months or days) Life

8. (a) PRINT FULL NAME Leslie James Holloway

8. (b) If veteran, NO name war NO
8. (c) Social Security No. 490-07-0179

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive years

7. Birth date of deceased MAR 7 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months X Days 16
If less than one day hr. min.

9. Birthplace Boone Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Automobile Painter

11. Industry or business Pearl Motor Co

12. Name Ed Holloway

13. Birthplace Boone Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name TINNIE PAYNE

15. Birthplace Boone County MO
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Holloway
(b) Address Columbia Mo

17. (a) Buried (b) Date thereof Mar 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rephel

18. (a) Signature of funeral director H. O. Weaver
(b) Address Columbia, Mo.

19. (a) 3/25/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone Co
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 1206 Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A. NO years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 23
year 1940 hour 11:00 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Concussion of Brain Duration

Due to Automobile accident

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence March 23 1940

(c) Where did injury occur? Highway 40 2 1/2 mi E. Columbia
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place Highway 40 2 1/2 mi E. Columbia

While at work? Yes (Specify type of place) (e) Means of injury Concussion

23. Signature W. R. Tolson M. D. Coroner
Address 218 N. 8th Columbia Date signed 3-25-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

210m
98

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed

Lyman H. Sprinkle

Licensed Embalmer No.

4013

P. O. Address

Columbia, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Leslie James Holloway

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 36 Months - Days 16 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. DATE OF DEATH Month mar day 23 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death Concussion of Brain

Due to automobile accident
Ran into truck on
Due to Highway 40.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. R. Tolson (M. D. or other) _____

Address Columbia Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-10150.